STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
FACILITY LICENSING AND INVESTIGATIONS SECTION

IN RE: Church Homes, Inc., Congregational of Hartford, CT.
d/b/a Noble Horizons
17 Cobble Road
Salisbury, CT 06606

CONSENT ORDER

WHEREAS, Church Homes, Inc., Congregational of Hartford, CT. (hereinafter the "Licensee"), has been issued License No.936-C to operate a Chronic and Convalescent Nursing Home known as Noble Horizons, (hereinafter the "Facility") under Connecticut General Statutes 19a-490 by the Department of Public Health, State of Connecticut (hereinafter the "Department"); and

WHEREAS, the Facility Licensing and Investigations Section (hereinafter "FLIS") of the Department conducted unannounced inspections on various dates commencing on May 17, 2005 and concluding on May 31, 2005; and

WHEREAS, the Department, during the course of the aforementioned inspection identified violations of the Connecticut General Statutes and/or Regulations of Connecticut State Agencies in a violation letter dated July 11, 2005 (Exhibit A – copy attached); and

WHERES, the Licensee is willing to enter into this Consent Order and agrees to the conditions set forth herein.

NOW THEREFORE, the FLIS of the Department acting herein and through Marianne Horn, its Section Chief, and the Licensee, acting herein and through Patrick Gilland, its President, hereby stipulate and agree as follows:

1. The Licensee shall execute a contract with an Independent Nurse Consultant (INC) approved by the Department within two (2) weeks of the effective date of this Consent Order. The INC's duties shall be performed by a single individual unless otherwise approved by the Department.
2. The INC shall function in accordance with FLIS's INC Guidelines (Exhibit B – copy attached). The INC shall be a registered nurse who holds a current and unrestricted license in Connecticut. The Registered Nurse assuming the functions of the INC shall not be included in meeting the nurse staffing requirements of the Regulations of Connecticut State Agencies.
3. The INC shall provide consulting services for a minimum of four (4) months at the Facility unless the Department identifies through inspections that a longer time period is necessary to ensure substantial compliance with applicable federal and state statutes and regulations. The INC shall be at the Facility twenty (20) hours per week and shall arrange his/her schedule in order to be present at the Facility at various times on all three shifts including holidays and weekends. The Department may, in its discretion, at any time, reduce or increase the hours of the INC and/or responsibilities, if the Department determines the reduction or increase is warranted. The terms of the contract executed with the INC shall include all pertinent provisions contained in this Consent Order.
4. The INC shall have a fiduciary responsibility to the Department.
5. The INC shall conduct and submit to the Department an initial assessment of the Licensee's regulatory compliance and identify areas requiring remediation within two (2) weeks after the contract is approved by the Department. The INC shall confer with the Licensee's Administrator, Director of Nursing Services, and other staff determined by the INC to be necessary to the assessment of nursing services and the Licensee's compliance with federal and state statutes and regulations. The INC shall make recommendations to the Licensee's Administrator, Medical Director and Director of Nursing Services for improvement in the delivery of direct resident care in the Facility. If the INC and the Licensee are unable to reach an agreement regarding the INC's recommendation(s),

the Department, after meeting with the Licensee and the INC shall make a final determination, which shall be binding on the Licensee.

6. The INC shall submit weekly written reports to the Department documenting:
    i. the INC's assessment of the care and services provided to residents;
    ii. the Licensee's progress toward substantial compliance with applicable federal and state statues and regulations;
    iii. any subsequent recommendations made by the INC and the Licensee's response to implementation of the recommendations.
7. Copies of all weekly INC reports shall be simultaneously provided to the Director of Nurses, Administrator, and Medical Director.
8. The INC shall have the responsibility for:
    a. Assessing, monitoring, and evaluating the delivery of direct resident care with particular emphasis and focus on the delivery of nursing services by registered nurses, licensed practical nurses, nurse aides, and orderlies and implementing prompt training and/or remediation in any area in which a staff member demonstrated a deficit. Records of said training and/or remediation shall be maintained for a period of three (3) years by the Licensee for review by the Department;
    b. Assessing, monitoring, and evaluating the coordination of resident care and services delivered by the various health care professionals providing services;
    c. Recommending to the Department an increase in the INC's contract hours if the INC is unable to fulfill the responsibilities within the stipulated hours per week; and
    d. Monitoring the implementation of the Licensee's plan of correction submitted in response to the violation letter dated July 11, 2005 (Exhibit A).
9. The INC, the Licensee's Administrator, and the Director of Nursing Services shall meet with the Department every six (6) weeks after the effective date of this Consent Order and throughout the tenure of the INC. The meetings shall include discussions of issues

related to the care and services provided by the Licensee and the Licensee's compliance with applicable federal and state statutes and regulations.

10. Any records maintained in accordance with any state or federal law or regulation or as required by this Consent Order shall be made available to the INC and the Department, upon request.
11. The Department shall retain the authority to extend the period the INC functions are required, should the Department determine that the Licensee is not able to maintain substantial compliance with federal and state laws and regulations. Examples of violations that may cause the Department to invoke this provision include, but are not limited to, failure to notify the physician of a significant change in condition; failure to provide care and treatment to residents identified with unstable health conditions; or failure to implement physician orders or plans of care. Determination of substantial compliance with federal and state laws and regulations will be based upon findings generated as the result of onsite inspections conducted by the Department.
12. The Director of Nursing Services and/or Assistant Director of Nursing Services shall conduct random unannounced visits at least two (2) times a week to the Facility to assess care/services being provided. Said visits shall occur on holidays, weekends, and shall include all three (3) shifts. Documentation of the assessment of care and services during to these visits shall be maintained and available for Department review, upon request.
13. The Licensee shall immediately notify the Department if the position(s) of Administrator, Director of Nurses, Assistant Director of Nurses, and/or Medical Director, the Infection Control Nurse, and/or MDS Coordinator become vacant due to resignations. In the event of a vacancy in any of these identified positions, the Administrator shall provide the Department with weekly reports pertaining to recruitment efforts until the position is refilled.
14. Effective upon the execution of this Consent Order, the Licensee, through its Governing Body, Administrator and Director of Nursing Services, shall ensure substantial compliance with the following:

a. Sufficient nursing personnel are available to meet the needs of the residents;
b. Resident treatments, therapies and medications are administered as prescribed by the physician and in accordance with each resident's comprehensive care plan;
c. Resident assessments are performed in a timely manner and accurately reflect the condition of the resident;
d. Each resident care plan is reviewed and revised to reflect the individual resident's problems, needs and goals, based upon the resident assessment and in accordance with applicable federal and state laws and regulations;
e. Nurse aide assignments accurately reflect resident needs;
f. Each resident's nutritional and hydration needs are assessed and monitored in accordance with his/her individual needs and plan of care; and
g. The personal physician or covering physician is notified in a timely manner of any significant changes in resident condition including, but not limited to, decline in skin integrity, presence of any infection, and deterioration of mental, physical, nutritional, and/or hydration status. In the event that the personal physician does not adequately respond to the resident's needs or if the resident requires immediate care, the Medical Director is notified.

15. Effective upon the execution of this Consent Order, the Licensee shall appoint a free floating Registered Nurse Supervisor on each shift whose primary responsibility is the assessment of residents and the care provided by nursing staff. A nurse supervisor shall maintain a record of any resident related issue(s) or problem(s) identified on his or her shift and a notation as to the subsequent action taken to resolve the problem(s). Such records shall be made available to the Department upon request and shall be retained for a three (3) year period.
16. Nurse Supervisors shall be employed by the facility and shall have previous supervisory experience. Nurse Supervisors shall not have a resident or resident unit assignment. In the event that a licensed nurse calls in sick, the Nurse Supervisor may take a unit assignment. Documentation of the reason for the Nurse Supervisor assuming a patient care assignment must be available for Department review.

17. Nurse Supervisors shall be provided with the following:
    a. A job description which clearly identifies the supervisor's day-to-day duties and responsibilities;
    b. An inservice training program which clearly delineates each Nurse Supervisor's responsibilities and duties with respect to resident and staff observations, interventions and staff remediation;
    c. Nurse Supervisors shall be supervised (includes reasonable on-site supervising as described below) and monitored by a representative of the Licensee's Administrative Staff, (e.g. Director of Nursing Service, or Assistant Director of Nursing Service) to ensure the Nurse Supervisors are functioning in accordance with this Consent Order and state and federal requirements. Said administrative supervising and oversight shall be provided on all three (3) shifts on an irregular schedule of visits. Records of such administrative visits and supervision shall be retained for the Department's review; and
    d. Nurse Supervisors shall be responsible for ensuring that all care is provided to residents by all caregivers in accordance with individual comprehensive care plans.
18. The Licensee, within seven (7) days of the execution of this document, shall designate and notify the Department of the name of the Facility employee responsible for monitoring the requirements of this Consent Order.
19. The Licensee shall establish a Quality Assurance Program (QAP) to review and monitor mechanisms implemented relative to resident care issues including those identified in the July 11, 2005 violation letter. The QAP Committee shall meet at least monthly to review and address the quality of care provided to residents and, if applicable, implement remediation measures. Membership shall at a minimum, include the Administrator, Director of Nurses, Infection Control Nurse, Nurse Supervisors, and the Medical Director. Minutes of the QAP meetings shall be kept for a minimum of three (3) years and made available for review upon request of the Department.

20. The Licensee shall pay a monetary penalty to the Department in the amount of two thousand, five hundred dollars ($2,500.00), by bank check or money order payable to the Treasurer of the State of Connecticut and mailed to the Department within (2) weeks of the effective date of this Consent Order. The monetary penalty and any reports required by this document shall be directed to:

Maureen Klett, R.N.,
Supervising Nurse Consultant
Facility Licensing and Investigations Section
Department of Public Health
410 Capitol Avenue, P.O. Box 340308, MS #12HSR
Hartford, CT 06134-0308

21. All parties agree that this Consent Order is an Order of the Department with all of the rights and obligations pertaining thereto and attendant thereon. Nothing herein shall be construed as limiting the Department's available legal remedies against the Licensee for violations of the Consent Order or of any other statutory or regulatory requirements, which may be sought in lieu of or in addition to the methods of relief listed above, including all options for the issuance of citations, the imposition of civil penalties calculated and assessed in accordance with Section 19a-524 et seq. of the General Statutes, or any other administrative and judicial relief provided by law. This Consent Order may be admitted by the Department as evidence in any proceeding between the Department and the Licensee in which compliance with its terms is at issue. The Licensee retains all of its rights under applicable law.
22. The execution of this document has no bearing on any criminal liability without the written consent of the Director of the MFCU or the Bureau Chief of the Department of Criminal Justice's Statewide Prosecution Bureau.
23. The terms of this Consent Order shall remain in effect for a period of two (2) years from the effective date of this document unless otherwise specified in this document.
24. The Licensee had the opportunity to consult with an attorney prior to the execution of this Consent Order.

IN WITNESS WHEREOF, the parties hereto have caused this Consent Order to be executed by their respective officers and officials, which Consent Order is to be effective as of the later of the two dates noted below.

CHURCH HOMES, INC., CONGREGATIONAL OF HARTFORD, CT. - LICENSEE

9/15/05
Date

By: _____
Patrick Gilland, its President

STATE OF Connecticut)

County of Litchfield) ss Salisbury, 9/15 2005

Personally appeared the above named Patrick J. Gilland and made oath to the truth of the statements contained herein.

My Commission Expires: 11-30-2005
(If Notary Public)

Marjorie C Wheaton
Notary Public [X]
Justice of the Peace [ ]
Town Clerk [ ]
Commissioner of the Superior Court [ ]

STATE OF CONNECTICUT,
DEPARTMENT OF PUBLIC HEALTH

9/16/05
Date

By: Marianne Horn
Marianne Horn, R.N., J.D., Section Chief
Facility Licensing and Investigations Section

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

EXHIBIT A
PAGE 1 OF 33

July 11, 2005

Ms. Eileen Mulligan,
Noble Horizons
17 Cobble Rd
Salisbury, CT 06068

Dear Ms. Mulligan:

Unannounced visits were made to Noble Horizons on May 17, 18, 19, 20, 23 and 24, 2005 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting a certification inspection with additional information received through May 31, 2005.

Attached are the violations of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which were noted during the course of the visits.

An office conference has been scheduled for July 26, 2005 at 10:00 AM in the Facility Licensing and Investigations Section of the Department of Public Health, 410 Capitol Avenue, Second Floor, Hartford, Connecticut.

The purpose of the meeting is to discuss the issues identified. Should you wish legal representation, please feel free to have an attorney accompany you to this meeting.

It will not be necessary for you to bring a plan of correction to this meeting as Department staff will be discussing alternative remedies to address the non-compliance issues identified during the course of the inspection.

No referrals of health care professionals were initiated as a result of this inspection.

If there are any questions, please do not hesitate to contact this office at (860) 509-7400.

Respectfully,

Lori Ann Griffin, RN, CRRN

Lori Ann Griffin, R.N., C.R.R.N
Supervising Nurse Consultant
Facility Licensing and Investigations Section

LAG: LSB:aij

c. Director of Nurses
Medical Director
President

Phone: (860) 509-7400
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 12HSR
P.O. Box 340308 Hartford, CT 06134
An Equal Opportunity Employer

DATES OF VISIT: May 17, 18, 19, 20, 23 and 24, 2005

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3).

1. Based on observation, facility documentation review and staff interview, the facility failed to prominently display Medicare and Medicaid benefit information and/or accurately identify services provided by the facility. The findings include:
   a. Tour of the facility on 5/19/05 at 4:00 PM identified that Medicare and Medicaid benefit information was posted on 2 of 3 units in the facility. Although Medicare and Medicaid benefit information was posted on the Wagner unit, it was located under a locked glass cabinet with only the first page of the information visible. Interview with the Administrator on 5/24/05 at 9:30 AM indicated that due to residents' removing the information, it was placed under glass.
   b. Review of the Admission packet with the Administrator on 5/19/05 at 9:30 AM identified that although ambulatory dialysis had not been provided for over twenty years, it remained in the Admission packet for marketing purposes. Additionally, the facility lacked Policies, Procedures and staff competencies for ambulatory dialysis.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1).

2. Based on review of the clinical record, facility documentation and staff interviews for 1 of 6 sampled residents (Resident # 7) with a decline in appetite and receiving pain medication and/or for 1 sampled resident (Resident # 7), with an excoriation and edema and/or for 1 sampled resident (Resident # 10), with injuries of unknown origin and/or for 1 sampled resident (Resident # 21) with a history of hemorrhoids, the facility failed to notify the physician in a timely manner. The findings include:
   a. Resident # 7's diagnoses included depression, renal insufficiency, acute renal failure, osteoarthritis and a history of edema of the lower extremities. The Minimum Data Set dated 3/8/05 identified intact memory, independence for eating and the presence of moderate bone and joint pain daily. The care plan dated 3/9/05 identified an alteration in nutrition with interventions that included to provide a regular diet and to encourage fluids with and between meals. A meal consumption record dated 3/5/05 through 3/17/05 indicated the resident refused fourteen (14) of thirty-eight (38) meals, ate less than twenty-five (25) percent of eleven (11) meals and 50 percent of ten (10) meals. Nurses' notes dated 3/6/05 through 3/15/05

indicated Resident #7 ate poorly and had no appetite. An Advanced Practice Registered Nurse (APRN) progress note dated 3/17/05 identified notification of decreased oral intake and indicated the resident was unable to eat due to the presence of unresolved left thigh pain secondary to a loosened prosthesis. A review of the clinical record on 5/19/05 at 11:00 AM with the Unit Manager failed to identify that the physician was notified of the decrease in oral intake until 3/17/05 (twelve days later).

i. The physician orders dated 3/4/05 directed to administer Ultram 50 milligrams (mg) three times a day for pain and Vicodin one tablet every four hours as needed for breakthrough pain. The Medication Administration Record dated 3/4/05 through 3/16/05 indicated twenty-seven (27) doses of Vicodin was administered for breakthrough left hip pain. The Pain Assessment record dated 3/4/05 through 3/16/05 identified that after the administration of Vicodin on 3/4/05, no pain relief was identified, and that on 3/5/05, "some" relief was obtained. The assessment further identified that on 3/8/05, 3/9/05, 3/10/05, 3/11/05, 3/12/05, and 3/15/05 pain was reduced from a level eight to level four, and that on 3/13/05 pain was reduced from a level six to level four. On 3/16/05 the physician was notified and directed to administer Roxinal 5.0 mg sublingual every two hours as needed for pain. A review of the clinical record with the Unit Manager on 5/19/05 at 11:00 AM failed to identify the physician was notified of the lack of pain relief from 3/4/05 until 3/16/05(thirteen days later).

ii. A hospital Discharge Summary dated 3/25/05 identified Resident #7 was re-admitted to the facility with a 2.0 centimeter (cm) open area on the right buttock. A physician's order dated 3/25/05 directed to apply duoderm to the right buttock and change every three days or as needed until healed. A nurse's note dated 3/28/05 identified a 2.0 cm by 0.5 cm open area on the left buttock, a 3.0 cm by 0.5 cm open area on the right buttock and both areas were cleansed and covered with duoderm. Interview with the Unit Manager on 5/19/05 at 10:00 AM indicated that the physician had not been notified of the new open area on the left buttock and/or the application of the duoderm.

iii. A significant change assessment dated 3/29/05 identified modified independence in decision- making abilities, intact memory and no edema. The care plan dated 4/6/05 identified acute renal failure with interventions that included to monitor for peripheral edema and to weigh the resident weekly. A nurse's note dated 4/12/05 identified bilateral three plus pedal edema when in bed. The nurse's note dated 4/14/05 indicated the presence of pedal edema and

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

protective elastic stockings were applied. A nurse's note dated 4/17/05 indicated both lower legs were very edematous and extremely uncomfortable to the resident. On 4/18/05 the physician was notified of the increased edema and directed to administer Aldactazide 50/50 one tablet oral daily. Review of the clinical record and interview with the Unit Manager on 5/19/05 10:20 AM failed to identify that the physician was notified of the bilateral pedal edema until to 4/18/05(four days later).

b. Resident #10's diagnoses included coronary artery disease and dementia with agitation. An assessment dated 1/26/05 identified short and long- term memory loss, severely impaired decision making abilities and extensive assistance required for transfers and ambulation. A care plan dated 2/2/05 identified that Resident #10 was receiving palliative care secondary to advanced dementia with interventions that included to assess for pain and administer pain medication as needed. Nurse's notes dated 4/5/05 at 7:00 PM identified that the resident complained of pain in the right wrist and edema was noted. A nurse's note dated 4/7/05 at 11:00 AM identified that the physician was notified and directed to administer Ibuprofen 400 milligrams (mg) three times a day as needed for joint pain. Interview and review of the clinical record with the Unit Manager on 5/18/05 at 3:15 PM identified that although pain and edema was noted in the right wrist on 4/5/05, the physician was not notified until 4/7/05 (two days later).

c. Resident # 21's diagnoses included dementia, osteoporosis and compression fractures. A physician order dated 2/17/05 directed to administer Tucks medicated pad topically to hemorrhoids as needed and Colace 100 milligrams once a day. An assessment dated 2/22/05 identified short-term memory loss, moderately impaired decision making abilities and extensive assistance required for bathing. A care plan dated 2/23/05 identified occasional incontinence with interventions that included to provide perineal care and to monitor skin condition. Nurse's notes dated 2/24/05 identified that after a bowel movement bleeding was noted and the hemorrhoids were noted to be enlarged and painful. A nurse's note dated 3/5/05 for the 11:00 PM -7:00 AM shift indicated hemorrhoid bleeding and on 3/5/05 at 4:30 PM bleeding was noted after a bowel movement and the hemorrhoids identified as "visible". Interview and review of the clinical record with the Care Plan Coordinator on 5/25/05 at 12:20 PM failed to identify that the physician was notified of the enlarged, external, bleeding hemorrhoids.

DATES OF VISIT: May 17, 18, 19, 20, 23 and 24, 2005

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2)(A).

3. Based on clinical record review, observation and staff interview for 2 of 40 sampled residents, (Resident #s 7 and 23), the facility failed to maintain confidentiality and privacy. The findings include:
   a. Resident #17's diagnoses included congestive heart failure and chronic renal insufficiency. A Minimum Data Set (MDS) dated 4/12/05 identified limited to extensive assistance was required for activities of daily living. A laboratory report dated 5/6/05 identified a positive result for clostridium difficile and a subsequent report dated 5/20/05 indicated a negative result for clostridium difficile. Observation on 5/17/05, 5/18/05, 5/19/05 and 5/20/05 identified a sign posted on the resident's door that indicated to don a gown and gloves prior to entering the room and to wash well with soap and water, not just alcohol wipes and gel. Interview on 5/23/05 at 10:00 AM with the Unit Manager indicated that signs are posted to alert the staff when a resident has clostridium difficile. The Unit Manager further stated the sign is removed after two negative laboratory reports.
   b. Resident #23's diagnoses included mild organic brain syndrome and hypertension. Observation on 5/17/05 at 9:00 AM with the Unit Manager identified a sign posted on the resident's door that indicated to use gloves, bag laundry separately and to dress the resident in long sleeves, a turtleneck and/or apply a dressing to cover the rash on the neck. Subsequent to surveyor inquiry, the posted sign was removed from the door.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (m) Nursing Staff (2)(A).

4. Based on observations, clinical record review, review of facility documentation and interviews for 2 of 2 sampled residents (Resident #s 5 and 11) who received medications without an order, the facility failed to conduct an assessment for self-administration of medications. The findings include:
   a. Resident #5 had diagnoses that included cerebral vascular accident with left hemiparesis and coronary artery disease. A Minimum Data Set (MDS) dated 2/15/05 identified intact memory and reasonable decision making ability. A nurse's note dated 2/18/05 indicated Person #1 administered cough medication to Resident #5 that was not ordered by the physician. Review of the clinical record and

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

interview on 5/18/05 at 3:00 PM with the Unit Manager failed to identify that Resident #5 was assessed for self-administration of medications. Additionally, a review of the Admission packet with the Admission Director on 5/24/05 at 9:00 AM failed to identify that information was provided to residents' and responsible parties in regards to administering medications without nursing notification.

b. Resident #11 had diagnoses that included cataracts, diabetes mellitus and hypertension. An assessment dated 4/26/05 identified the resident was cognitively intact, non-ambulatory, with severely impaired vision and with limitation in range of motion of the right hand. A care plan dated 4/27/05 identified a loss of vision with interventions that included to anticipate the resident's needs. Observations on 5/18/05 at 10:00 AM identified a basket between the resident's bed and recliner chair that contained an unlabelled bottle of medication. The resident indicated the medication that was used occasionally for heartburn was from two years ago. Interview with the Nurse Manager on 5/18/05 at 10:30 AM identified that she was not aware Resident #11 had been self- administering the medication.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (o) Medical Records (2)(H) and/or Connecticut General Statutes 19a-550.

5. Based on clinical record review, interviews and review of facility documentation for 3 of 3 sampled residents (Resident #s 9, 10, and 21), who utilized a restraint, the facility failed to conduct an assessment for the use of the restraint. The findings include:
   a. Resident # 9's diagnoses included diabetes, hypothyroidism and chronic obstructive pulmonary disease. An assessment dated 12/17/04 identified short and long-term memory deficits and extensive assistance required for transfers and no use of restraints. The care plan dated 12/22/04 identified decreased strength following a fall with interventions that included the use of two siderails in bed to facilitate turning and positioning and physical and occupational therapy to increase strength and endurance. Review of the restraint assessment dated 12/21/04 identified Resident #9 did not utilize a restraint. A caregiver training record dated 12/24/04 identified the use of a lap buddy in the wheelchair. Interview and review of the clinical record with the Unit manager on 5/19/05 at 11:10 AM and with the Physical Therapist on 5/19/05 at 11:30 AM failed to provide evidence that although the resident was unable to remove the lap buddy, an assessment for restraint use was not completed.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

b. Resident #10's diagnoses included coronary artery disease and dementia with agitation. An assessment dated 4/20/05 identified short and long-term memory loss, severely impaired decision making abilities and extensive assistance required for transfers and ambulation. A care plan dated 4/27/05 identified a risk for falls with interventions that included the use of a motion detector when in bed, personal alarm and lap buddy in the wheelchair. Observations on 5/17/05 at 11:30 AM and 12:00 PM noted Resident#10 seated in a wheelchair in the Special Care activity room with a lap buddy and personal alarm in place. Interview and review of the clinical record with the Unit Manager on 5/18/05 at 3:00 PM failed to provide documentation that the resident could remove the lap buddy on command and that an assessment for the least restrictive device was completed prior to implementation of the lap buddy.

c. Resident # 21's diagnoses included dementia, osteoporosis and compression fractures. An assessment dated 2/22/05 identified short-term memory loss, moderately impaired decision making abilities and limited assistance required for transfers and ambulation. A care plan dated 2/23/05 identified poor safety awareness with interventions that included to use a motion detector when in the room and a personal alarm at all times. A nurse's note dated 3/19/05 identified that Resident #21 continued to stand without assistance and a lapbuddy was added to the wheelchair. Interview and review of the clinical record with the Care Plan Coordinator on 5/25/05 at 12:20 PM failed to identify that an assessment for the least restrictive device was completed prior to implementation of the lap buddy.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (g) Reportable Event (6).

6. Based on clinical record review, interviews and review of facility documentation for one sampled resident in the survey (Resident #10), with unexplained injuries, the facility failed to conduct an investigation in a timely manner. The findings include:
   a. Resident #10 diagnoses included coronary artery disease and dementia with agitation. As assessment dated 1/26/05 identified short and long- term memory loss, severely impaired decision making abilities and extensive assistance required for transfers and ambulation. A care plan dated 2/2/05 identified that Resident #10 received palliative care due to advanced dementia with interventions that included to assess for pain and administer pain medication as needed. A nurse's notes dated 4/5/05 at 7:00 PM identified a new onset of pain and edema in the right wrist. A nurse's note dated 4/7/05 at 11:00 AM indicated the physician was notified and

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

directed to administer Ibuprofen 400 milligrams (mg) three times a day as needed for joint pain. Interview and review of the clinical record with the Unit Manager on 5/18/05 at 11:00 AM failed to provide evidence that an investigation was initiated after the identification of pain and edema of the right wrist.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3)(D) and/or Connecticut General Statutes 19a-550.

7. Based on clinical record review, observation, and interviews for 1 of 10 sampled resident (Resident #10), who had a history of falls and for 1 of 21 sampled residents (Resident #14), who required assistance with grooming, the facility failed to administer care and services in a dignified manner. The findings include:
   a. Resident # 10's diagnoses included coronary artery disease and dementia with agitation. An assessment dated 4/20/05 identified short and long-term memory loss, severely impaired decision making abilities and extensive assistance required for transfers and ambulation. A care plan dated 4/27/05 identified advanced dementia with interventions that included to provide one to one supervision as much as possible, a private duty nurse aide from 9:00 PM -7:00 AM daily and a mattress on the floor. Observations of the resident's room on 5/17/05 at 9:30 AM identified a mattress on the floor with an egg crate mattress on either side. Interview and review of the clinical record with the Unit Manager on 5/18/05 at 11:10 AM indicated that although the facility had access to low beds, a low bed trial was not attempted prior to the placement of the mattress on the floor. The Unit Manager indicated that Resident #10 was required to crawl on their hands and knees to access the mattress.
   b. Resident#14 's diagnoses included dementia. The quarterly assessment dated 3/24/05 identified that the resident was cognitively impaired and was totally dependent for personal hygiene. The care plan dated 3/31/05 identified total assistance required for activities of daily living with interventions that included to provide assistance with hygiene. Observation on 5/18/05 at 7:50 AM identified Resident #14 seated in the lounge while staff removed facial hair in the presence of five other residents. Upon surveyor presence, the resident was removed to the bath suite to complete the grooming.

DATES OF VISIT: May 17, 18, 19, 20, 23 and 24, 2005

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3) and/or (s) Social Work (7).

8. Based on clinical record review, facility documentation review and interviews for 1 of 13 sampled residents (Resident #11), with mood and behavior indicators, the facility failed to provide psychosocial services to address the needs of the resident. The findings include:
   a. Resident #11's diagnoses included depression, cataracts, syringomyelia and hypertension. A quarterly assessment dated 1/31/05 identified the resident as cognitively intact with highly impaired vision, repetitive health complaints and tearfulness. A care plan dated 2/2/05 identified episodes of tearfulness, neediness and mood swings with interventions that included frequent one to one visits, reassurance and validation when anxious or emotional. Nurse notes dated 3/8/05 identified that Resident #11 verbalized emotional disturbance and exhibited paranoid behavior regarding the lack of visits by a staff member. Although, the Nursing Supervisor provided an explanation, Resident #11 indicated the avoidance was purposeful. The Advanced Practice Registered Nurse (APRN) notes dated 3/9/05 and 3/10/05 identified Resident #11 remained distraught over the incident stating the problem will never be resolved. Interview and review of the clinical record with the Director of Social Services on 5/24/05 at 9:00 AM identified although the plan of care was discussed with the APRN, she did not visit or complete an assessment of the resident after the incident.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (m) Nursing Staff (2)(A).

9. Based on clinical record review and interviews for 3 of 13 sampled residents (Resident #s 5, 7 and 21), who required assistance with toileting, the facility failed to conduct assessments of bowel activity. The findings include:
   a. Resident #5 had diagnoses that included breast cancer, cerebral vascular accident with left hemiparesis, limb pain, costochondritis, and severe emphysema. The Minimum Data Set (MDS) dated 2/15/05 identified the resident was alert and oriented, required independent to extensive assistance for activities of daily living and continence of bowel. A physician order dated 3/1/05 directed to administer OxyContin 10 milligrams (mg) every twelve hours for pain and Oxycodone 10 mg every four hours for breakthrough pain. A review of the March and April 2005

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Medication Administration Record failed to identify that consistent monitoring for bowel activity was completed. Interview with the Unit Manager on 5/18/05 at 3:45 PM indicated that bowel monitoring was not completed consistently because Resident # 5 is alert and oriented and utilizes the bathroom. The Unit Manager stated nursing staff relies on an alert resident to report the need to implement the bowel regimen.

b. Resident # 7's diagnoses included depression, renal insufficiency and osteoarthritis. A physician order dated 3/4/05 directed to administer Vicodin one tablet every four hours as needed for breakthrough pain. A physician order dated 3/5/05 directed to administer Senokot one tablet once a day and Milk of Magnesia 30 cubic centimeters (cc) by mouth every three days as needed for constipation. A Minimum Data Set dated 3/8/05 identified intact memory, moderate pain experienced on a daily basis, continence of bowel and the lack of regular bowel activity. A nurse's note dated 3/5/05 indicated manual assistance was required to remove constipated stool from the rectum. The March 2005 Medication Administration Record (MAR) indicated twenty-seven (27) doses of Vicodin was administered from 3/4/05 through 3/16/05 for breakthrough pain. The MAR further indicated no bowel activity occurred from 3/7/05 through 3/11/05 (five days). A nurse's notes dated 3/12/05 identified the resident reported being constipated and Milk of Magnesia 30 cc was administered. A large amount of liquid stool was evacuated, however a digital assessment noted palpable hard stool. After manual removal of a small amount of hard stool, the resident evacuated a large amount of liquid light brown stool. Interview with the Unit Manager on 5/18/05 at 11:40 AM indicated that unless there is a problem, staff does not monitor bowel activity for alert and oriented residents. The Unit Manager indicated that staff relies on the residents to report any issues with constipation.

c. Resident # 21's diagnoses included dementia, osteoporosis and compression fractures. An assessment dated 2/22/05 identified short-term memory loss, moderately impaired decision making abilities, extensive assistance required for toileting and occasional incontinence of bowel. A care plan dated 2/23/05 identified occasional bowel incontinence with interventions that included to provide perineal care after each incontinent episode and monitor skin condition. Nurse's notes dated 2/24/05 identified that after a bowel movement, bleeding was noted and hemorrhoids were noted to be enlarged and painful. On 3/5/05 at 4:30 PM a nurse's note identified that bleeding was noted after a bowel movement and was thought to be from the enlarged external hemorrhoids. A review of the March Medication Administration Record identified bowel activity was not monitored on 3/1/05,

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3/6/05, 3/7/05, 3/8/05, 3/14/05, 3/15/05 and 3/16/05 (7 days). Review of the clinical record and interview with the Care Plan Coordinator on 5/24/05 at 12:20 PM failed to provide evidence that bowel activity was monitored on a consistent basis.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (o) Medical Records (2)(H).

10. Based on clinical record review, review of facility documentation and interviews for 1 of 10 sampled residents (Resident # 8), with a history of falls and/or for 2 of 5 sampled residents (Resident #s 1 and 8), who utilized side rails, the facility failed to accurately code the Minimum Data Set. The findings include:
    a. Resident #1 had diagnoses that included osteoporosis, depression and quadriplegia. An assessment dated 4/7/05 identified modified independence in cognitive ability, non-ambulatory, required assistance with bed mobility and utilized full side rails as a restraint. A care plan dated 4/14/05 identified a self- care deficit with interventions that included to provide assistance with activities of daily living. Observation on 5/17/05 at 8:45 AM identified the resident in bed with both side rails up. Interview with the Unit Manager on 5/18/05 at 8:45 AM indicated the side rails were used for repositioning and did not prevent the resident from getting out of bed. The Unit Manager reported the Minimum Data Set (MDS) was inaccurately coded.
    b. Resident #8 diagnoses included hypertension and abdominal aneurysm. Facility documentation dated 9/10/04 identified that Resident #8 experienced a fall. A quarterly assessment dated 12/8/04 identified short- term memory loss and extensive assistance required for transfers, restraints were utilized daily and no falls occurred within the last six months. Review of the quarterly assessment and interview with the Unit manager and the Care Plan Coordinator on 5/18/05/at 9:50 AM identified that although a fall had occurred it was not coded on the quarterly assessment. The Unit Manager further stated the siderails were used as a position enabler and not a restraint and were coded incorrectly on the quarterly assessment.

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The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (o) Medical Records (2)(I).

11. Based on clinical record review, interviews and review of facility documentation for 1 of 6 sampled residents (Resident #7), who received narcotic medication and/or for 1 of 1 sampled resident (Resident #21), who had hemorrhoids and/or for 1 of 1 sampled residents, (Resident #7), with lower extremity edema, the facility failed to develop a comprehensive plan of care. The findings include:
    a. Resident # 7's diagnoses included depression, renal insufficiency, a history of edema in the lower extremities and osteoarthritis. The Minimum Data Set dated 3/8/05 identified intact memory and the presence of moderate bone and joint pain daily. The physician's orders dated 3/4/05 directed to administer Ultram 50 milligrams (mg) three times a day for pain and Vicodin one tablet every four hours as needed for breakthrough pain. The Medication Administration Kardex dated 3/4/05 through 3/16/05 indicated twenty-seven (27) doses of Vicodin was administered for breakthrough left hip pain. Review of the care plan with the Unit Manager on 5/19/05 at 10:20 AM failed to identify that interventions to address potential side effects from narcotic medication were implemented.
        i. A significant change assessment dated 3/29/05 identified modified independence in decision- making abilities, intact memory and no edema. The care plan dated 4/6/05 identified acute renal failure with interventions that included to monitor for peripheral edema and to weigh the resident weekly. A nurse's note dated 4/12/05 identified bilateral three plus pedal edema when in bed. The nurse's note dated 4/14/05 indicated the presence of pedal edema and protective elastic stockings were applied. A nurse's note dated 4/17/05 indicated both lower legs were very edematous and extremely uncomfortable to the resident. On 4/18/05 the physician was notified of the increased edema and directed to administer Aldactazide 50/50 one tablet oral daily. On 4/23/05 the edema was measured at three plus and on 4/27/05 the nurse's note described improvement in the edema, however did not include a measurement. Subsequent edema assessments were completed on 5/10/05, 5/11/05 and 5/14/05. Review of the care plan and interview with the Unit Manager on 5/19/05 at 10:20 AM failed to identify that specific interventions to address when edema monitoring was to be completed were implemented. The Unit Manager stated monitoring edema every three to four days was sufficient for a resident with a diagnosis of chronic edema.

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b. Resident # 21's diagnoses included dementia, osteoporosis and compression fractures. An assessment dated 2/22/05 identified short-term memory loss, moderately impaired decision making abilities, extensive assistance required for toileting and occasional incontinence of bowel. A care plan dated 2/23/05 identified occasional bowel incontinence with interventions that included to provide perineal care after each incontinent episode and monitor skin condition. Nurse's notes dated 2/24/05 identified that after a bowel movement, bleeding was noted and the hemorrhoids were noted to be enlarged and painful. On 3/5/05 at 4:30 PM a nurse's note identified that bleeding was noted after a bowel movement and was thought to be from the enlarged external hemorrhoids. Review of the clinical record and interview with the Care Plan Coordinator on 5/25/05 at 12:20 PM failed to identify that the care plan reflected a diagnosis of hemorrhoids or that interventions were implemented.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (o) Medical Records (2)(I).

12. Based on clinical record review, facility documentation review and interviews for 1 of 13 sampled residents (Resident #11) with mood and behavior symptoms, and/or for 3 of 10 sampled residents (Resident #s 5, 11 and 21) with a history of falls, the facility failed to review and revise the plan of care after a fall. The findings include:
    a. Resident #5's diagnoses included cerebral vascular accident with hemiparesis and atrial fibrillation. A Minimum Data Set dated 12/8/04 identified intact memory and independence for ambulation and transfer, partial loss of function on one side and a history of falls. A care plan dated identified a history of falls with interventions that included to ambulate independently. A nurse's note dated 2/3/05 at 3:00 PM indicated Resident #5 lost her balance when ambulating and fell. An assessment identified a bruise on the left hip and right knee and required transfer to the Emergency Department for an evaluation. Nurses notes dated 2/5/05 at 6:00 AM indicated Resident #5 lost her balance and slid to the floor striking her head. On 2/6/05 at 9:30 PM a nurse's note indicated Resident #5 fell on the floor. An assessment identified slurred speech, shortness of breath and a heart rate of one hundred twenty-two (120) beats per minute. The physician was notified and directed to transfer to the Emergency Department for an evaluation. A review of the care plan with Unit Manager on 5/19/05 at 11:00 AM failed to identify that after a

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fall on 2/3/05 and 2/5/05 the plan of care was reviewed and/or revised or interventions implemented.

b. Resident #11 had diagnoses that included depression, cataracts, syringomyelia and hypertension. A quarterly assessment dated 1/31/05 identified the resident was cognitively intact, highly impaired vision, a history of falls, repetitive health complaints, crying and tearfulness. A care plan dated 2/2/05 identified episodes of tearfulness and mood swings with interventions that included to provide reassurance and validation when anxious or emotional and to monitor signs and symptoms of depression. An Advanced Practice Registered Nurse (APRN) progress note dated 3/9/05 identified an increase agitation and depression related to a staff member. A physician order dated 3/10/05 directed to administer Risperdal 0.25 milligrams (mg) twice a day. Clinical record review and interview with the Minimum Data Set Coordinator on 5/18/05 at 3:45 PM failed to identify that interventions were initiated to address potential side effects of the antipsychotic medication.

   i. A nurse's note dated 3/8/05 identified Resident #11 verbalized emotional disturbance and increase agitation in regards to a staff member. Review of the care plan and interview with the Advanced Practice Registered Nurse (APRN) and Minimum Data Set Coordinator on 5/18/05 at 3:45 PM failed to provide evidence that although emotional distress related to a care giver was identified, the care plan was reviewed and/or interventions implemented.

c. Resident # 21's diagnoses included dementia, osteoporosis and compression fractures. An assessment dated 2/22/05 identified short-term memory loss, moderately impaired decision making abilities, limited assistance required for transfers and ambulation and a history of falls. A care plan dated 2/23/05 identified poor safety awareness with interventions that included to utilize a motion detector when in the room and personal alarm at all times. A nurse's note dated 3/20/05 at 11:30 AM identified Resident #21 was found on the floor after removing the personal alarm. Upon assessment, pain was noted in the right hip and the physician was notified. An x-ray performed at the hospital was negative for injury and the resident returned to the facility. A nurse's note dated 3/22/05 at 5.00 AM identified Resident#11 was found lying on the floor complaining of severe right hip and back pain. The personal alarm had been removed and the motion detector did not sound. The physician was notified and directed to transfer to the emergency room for an evaluation. The hospital admission summary dated 3/22/05 indicated Resident #21 was admitted to the hospital with a diagnosis of left hip fracture. Interview and review of the clinical record with the Director of Nurses at 5/25/05 at 12:15 PM

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failed to identify that after the fall on 3/20/05, the care plan was reviewed and/or new interventions initiated.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (m) Nursing Staff (2)(A).

13. Based on clinical record review, review of facility policy and procedures and interviews for 1 of 4 residents (Resident # 1), with a pressure ulcer and/or for 1 sampled resident (Resident # 6), who received Digoxin and/or for 1 of 2 sampled residents (Resident #19), on a fluid restriction and/or for 1 sampled resident (Resident # 7), at risk for dehydration, the facility failed to maintain acceptable standards of practice. The findings include:
    a. Resident#1 had diagnoses that included paraplegia, anemia, renal insufficiency and osteoporosis. An assessment dated 1/13/05 identified the resident with intact cognition, non-ambulatory, incontinence of bowel and bladder and a Stage II pressure ulcer. A care plan dated 1/20/05 identified an open area on the coccyx with interventions that included scheduled bedrest, a pressure- relieving mattress and to apply Silvadene cream followed by a dry sterile dressing every shift. Review of the Pressure Ulcer Assessment dated 2/10/04 through 4/11/05 with the Unit Manager on 5/18/05 at 12:00 PM identified that although tracking was completed on a weekly basis, the assessment failed to consistently include drainage, size and appearance of the wound. According to Mosby's The Prevention and Treatment of Pressure Ulcers 2001, pages 99-115, items on the pressure sore status tool are size, depth, undermining, necrotic tissues type, necrotic tissue amount, exudates amount and epithelialization.
    b. Resident #5's diagnoses included cerebral vascular accident with left hemiparesis, hypertension, limb pain and costochondritis. The Minimum Data Set (MDS) dated 2/15/05 identified intact cognition and independence with ambulation and transfer. A nurse's note dated 2/14/05 identified Resident #5 indicated she twisted her right leg (unwitnessed) while standing by her wheelchair. Additionally, right groin pain and the inability to bear weight on the right leg was noted. Review of the clinical record and interview with the Unit Manager on 5/19/05 at 11:30 AM failed to provide evidence that an assessment of the right leg and groin was completed. According to The Illustrated Manual of Nursing Practice, Third Edition, 2001, after a trauma, the patient should be checked for obvious wounds, deformities or edema. The area should be palpated for tenderness and swelling and pulses and skin temperature should be compared. Particular attention should be paid to skin color

and pulse rates in an injured extremity and sensation, strength of movement and range of motion should be tested where applicable.

c. Resident #6 had diagnoses that included atrial fibrillation. An assessment dated 4/13/05 identified short and long-term memory deficits and independence in activities of daily living except for bathing. A February 2005 physician order directed to administer Digoxin 0.25 milligrams (mg) daily. The March and April 2005 Medication Administration Record identified that although Digoxin 0.25 mg was administered daily, an apical or radial pulse was not obtained prior to the administration of the medication. Interview with the Unit Manager on 5/18/05 at 2:30 PM identified that facility policy directs to obtain an apical and/or radial pulse for the first thirty days a resident receives Digoxin and only thereafter if there is a change in condition. According to Nursing 2005 Drug Handbook pages 227 through 229, before giving the drug (Digoxin), take an apical and/or radial pulse for one minute. Record and notify the subscriber of significant changes.

d. Resident# 7 had diagnoses that included depression, renal insufficiency and osteoarthritis. An assessment dated 12/22/04 identified intact cognition and independence for eating. The care plan dated 12/29/04 identified a potential for impaired nutrition and hydration with interventions that included to encourage fluids with and in between meals. The meal consumption record dated 3/5/05 through 3/17/05 indicated that the resident refused fourteen (14) of thirty-eight (38) meals ate less than twenty-five (25) percent (%) of eleven (11) meals and fifty (50)% of ten (10) meals. A 3/17/05 Advanced Practice Registered Nurse's (APRN) progress note indicated that Resident#7 was unable to eat because of left hip and thigh pain and was noted with dry mucous membranes of the mouth. The physician was notified and Resident #7 was admitted to the hospital with a diagnosis of dehydration. Interview with the Director of Nurses on 5/19/05 at 9:30 AM identified the facility lacked and/or failed to develop Intact and Output, Dehydration and/or Hydration Assessment Policies and Procedures. According to Lippincott's Pocket Manual of Nursing Practice, copyright dated 2003 pages 288, 289, 205, 894-895 assessment of degree of dehydration includes monitoring mucous membranes, skin turgor, eyes, intake and output and thirst.

e. Resident#19 had diagnoses that included end-stage liver disease. An admission assessment dated 3/14/05 identified intact cognition and independence in activities of daily living. The admission care plan care plan dated 3/16/05 identified a fluid restriction with interventions that included to obtain intake and output and daily weights. A nurse's note dated 3/28/05 indicated Resident #19 was discharged home. Review of the clinical record with the Director of Nurses on 5/24/05 at 1:00

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PM identified that although intake was obtained on a daily basis, urine output was only recorded on 3/12/05, 3/13/05 and 3/17/05 on the 3-11 shift. Additionally, daily weights were not recorded on 3/17/05, 3/19/05, 3/20/05, 3/23/05, 3/25/05, 3/26/05, 3/27/05 (seven of twelve days). According to Clinical Nursing Skills, Fifth Edition, 2000, Complete and accurate charting is essential to protect both the patient and the nurse. Since charting describes nursing interventions and their outcomes, other healthcare personnel can determine if subsequent treatments should be changed. Frequently a patient's reaction time is nearly as important as the reaction is itself; therefore accuracy of time observations becomes an integral part of the charting process.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (m) Nursing Staff (2)(A).

14. Based on clinical record review and staff interviews for 1 sampled resident (Resident #6), with a recommendation for a vitamin and/or for 2 of 3 sampled residents (Resident #s 19 and 22) who required intake and output, the facility failed to follow the plan of care. The findings include:
    a. Resident#6 had diagnoses that included atrial fibrillation, hypercholesteremia. The Minimum Data Set (MDS) dated 4/13/05 identified the resident with short and long term memory deficits and independence for eating. A care plan dated 4/20/05 identified a risk for nutrition impairment with interventions that included to encourage a regular diet and nutritional intake. A dietary progress note dated 4/20/05 identified Resident # 6 consumed seventy-five percent (75%) of meals and did not eat snacks between meals and a calcium supplement was recommended. Interview and review of the April and May 2005 physician orders with the Unit Manager on 5/8/05 at 4:15 PM failed to identify a calcium supplement had been ordered. In an interview the Unit Manager stated that the resident did not have a diagnosis of osteoporosis and therefore she did not feel the calcium was required.
    b. Resident #19 had diagnoses that included end-stage liver disease. An admission assessment dated 3/14/05 identified intact cognition and independence in activities of daily living. The admission care plan care plan dated 3/16/05 identified a fluid restriction with interventions that included to obtain intake and output and daily weights. A nurse's note dated 3/28/05 indicated Resident #19 was discharged home. Review of the clinical record with the Director of Nurses on 5/24/05 at 1:00 PM identified that although intake was obtained on a daily basis, urine output was

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not recorded on 3/16/05, 3/18/05, 3/19/05, 3/20/05, 3/21/05, 3/22/05, 3/23/05, 3/24/05, 3/26/05 and 3/27/05 (ten of twelve days). Additionally, daily weights were not recorded on 3/17/05, 3/19/05, 3/20/05, 3/23/05, 3/25/05, 3/26/05, 3/27/05 (seven of twelve days).

c. Resident #22's diagnoses included Paget's disease, fractured left hip and hypertension. An admission Minimum Data Set (MDS) dated 4/18/05 identified severe cognitive impairment, extensive to total assistance required for activities of daily living, twenty-five percent or more of food uneaten at meals and an indwelling catheter. A care plan dated 4/28/05 identified an unrepaired fracture left hip with interventions that included to obtain intake and output daily. Review of the clinical record with the MDS Coordinator on 5/19/05 at 3:30 PM identified that on 4/16/05, 4/18/05, 4/29/05, 4/30/05, 5/6/05, 5/7/05, 5/9/05, 5/10/05, 5/11/05, 5/13/05, and 5/15/05 intake and output was not consistently recorded (eleven days).

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (m) Nursing Staff (2)(A).

15. Based on clinical record review and interview for 1 sampled resident (Resident #6) who received Digoxin, the facility failed to obtain bloodwork and/or an apical pulse rate as ordered by the physician. The findings include:
    a. Resident#6's diagnoses included atrial fibrillation. An assessment dated 2/1/05 identified short and long-term memory deficits and independence in activities of daily living. A January 2005 physician order directed to administer Digoxin 0.25 milligrams (mg) daily. An Advanced Practice Registered Nurse (APRN) progress note dated 3/15/05 identified atrial fibrillation with a bradycardia rate. An APRN order dated 3/15/05 directed to obtain an apical pulse every shift for five days. Review of the Medication Administration Record with the Unit Manager on 5/18/05 at 2:30 PM failed to identify that an apical pulse rate was obtained on 3/15/05, 3/16/05, 3/17/05 and 3/18/05 on the 3-11 PM shift.
    b. A pharmacy consultation dated 1/1/05 indicated a Digoxin level was obtained on May 5, 2004 with a recommendation to obtain a Digoxin level. An Advanced Practice Registered Nurse (APRN) order dated 3/15/05 directed to obtain a Digoxin level on the next scheduled laboratory day. A laboratory report was obtained on 3/16/05 and identified a Digoxin level of 1.5 ng/ml (normal 0.8-2.0 ng/ml) two months and fifteen days after recommended by the Pharmacist. The Unit Manager

in an interview on 5/18/05 at 2:30 PM stated the Digoxin level was not obtained until 3/16/05 because the pharmacy recommendation was overlooked.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (m) Nursing Staff (2)(A).

16. Based on observations, clinical record review and interviews for 2 of 4 sampled residents (Resident #s 1 and 7), with a pressure ulcer, the facility failed to consistently monitor the pressure ulcer. The findings include:
    a. Resident #1's diagnoses included paraplegia, anemia, renal insufficiency and osteoporosis. An assessment dated 1/13/05 identified the resident with no cognitive deficits, non-ambulatory, incontinence of bowel and bladder and a Stage II pressure ulcer. A care plan dated 1/20/05 identified a slowly improving open area on the coccyx with interventions that included scheduled bedrest, pressure relieving mattress and to apply Silvadene cream followed by dry sterile dressing every shift as ordered. A nurse's note dated 3/22/05 identified a new small bleeding open area on the right buttock. A nurse's note dated 3/23/05 identified that Silvadene cream was applied to the abraded area. On 3/30/05, a nurse progress note indicated the open area to the right of coccyx wound was enlarged. Although a pressure ulcer was present, a review of clinical record and interview on 5/18/05 at 12:00 PM with the Unit Manager failed to identify documentation of the right buttock pressure ulcer after 3/30/05. Additionally, the clinical record lacked evidence that pressure ulcer monitoring was conducted after 3/30/05.
    b. Resident # 7 was re-admitted to the facility on 3/25/05 with diagnoses that included depression, renal insufficiency and osteoarthritis. The admission nursing assessment identified a 2.0 centimeter (cm) open area on the buttocks and boggy bilateral heels. The Minimum Data Set dated 3/29/05 identified one Stage II pressure ulcer. The care plan dated 3/30/05 identified an open area with interventions that included to apply Duoderm every three days and to monitor for healing. A physician order dated 3/25/05 directed to apply Duoderm to the right buttock and change every three days or as needed until healed. A nurse's note dated 3/25/05 identified a 2.0 centimeter (cm) open area on the right buttocks. A nurse's note dated 3/28/05 noted a new 2.0 cm by 0.5 cm open area on the left buttock and a 3.0 cm by 0.5 cm open area on the right buttock. A nurse progress note dated 4/18/05 indicated the open area on the right buttock was healed. A review of the clinical record and interview with the Unit Manager on 5/19/05 at

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11:00 AM failed to identify that pressure ulcer monitoring of the open areas on the buttocks were completed after 3/28/05. Furthermore, the clinical record lacked documentation that monitoring of the bilateral boggy heels was conducted. The Unit Manager stated the facility utilized a pressure ulcer tracking form and the nurse that provides the wound treatment is responsible for documenting the characteristics of the pressure ulcer.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3) and/or (j) Director of Nurses (2) and/or (m) Nursing Staff (2)(A).

17. Based on clinical record review and staff interviews for 1 of 13 sampled residents (Resident #11), with mood and behavior indicators, the facility failed to provide recommended treatment and services. The findings include:
    a. Resident #11's diagnoses included depression, cataracts, syringomyelia and hypertension. A quarterly assessment dated 1/31/05 identified intact cognition, highly impaired vision, repetitive health complaints and tearfulness. A care plan dated 2/2/05 identified episodes of tearfulness, neediness and mood swings with interventions that included frequent one to one visits, reassurance and validation when anxious or emotional. A nurse's note dated 3/8/05 identified that Resident #11 verbalized emotional disturbance and exhibited paranoid behavior. An Advanced Practice Registered Nurse (APRN) progress note dated 3/9/05 identified the resident remained upset, felt useless and cried throughout the interview. Recommendations included to increase the dose of anti-depressant, re-evaluate in two weeks and visit weekly. An APRN progress note dated 3/10/05 identified irrational behavior, ruminating with paranoid ideations and Risperdol 0.25 milligrams twice a day was ordered. Review of the clinical record and interview with the APRN on 5/18/05 at 3:45 PM failed to provide evidence that weekly visits and/or a re-evaluation of the resident's psycho-social status was conducted until 4/11/05. Additionally, a review of the clinical record failed to provide evidence the consultant Psychiatrist conducted an evaluation of the resident within the past year.

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The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (m) Nursing Staff (2)(C).

18. Based on clinical record review, interviews and review of facility documentation for 4 of 10 sampled residents (Resident #s 8, 11, 17 and 21), with a history of falls, the facility failed to follow the plan of care and/or provide adequate supervision to prevent an accident. The findings include:
    a. Resident #8 diagnoses included hypertension. An assessment dated 12/8/04 identified short term memory loss and extensive assistance required for transfers. A care plan dated 12/15/04 identified a potential for falls with interventions that included a motion detector when in the room and frequent safety checks. A nurse's note dated 12/30/04 at 4:15 PM indicated the resident was found on the floor at the foot of the bed and no injuries were identified. Interview and review of facility documentation dated 12/30/04 with the Unit Manager on 5/18/05 at 9:50 AM failed to provide evidence that the motion detector was on and/or functioning at the time of the fall.
    b. Resident#11 had diagnoses that included depression, cataracts, syringomyelia and hypertension. A quarterly assessment dated 1/31/05 identified intact cognition, highly impaired vision and a history of falls. A care plan dated 2/2/05 identified a potential for falls due to poor balance and muscle weakness with interventions that included to keep the call bell within easy reach and to elicit staff assistance when items are dropped. The care plan further identified a desire for independence with interventions that included to keep the resident safe. A nurse's note dated 3/8/05 identified that Resident #11 verbalized emotional disturbance and exhibited paranoid behavior. An Advanced Practice Registered Nurse (APRN) progress note dated 3/9/05 identified the resident remained upset, felt useless and cried throughout the interview. Recommendations included to increase the dose of Elavil (anti-depressant), re-evaluate in two weeks and weekly visits. An APRN progress note dated 3/10/05 identified irrational behavior, ruminating with paranoid ideations and Risperdol 0.25 milligrams twice a day was ordered. A nurse's note dated 4/1/05 indicated Resident #11 was found sitting on the floor. On 4/5/05 the resident was found on the floor stating he fell backwards and sustained a 12.0 centimeter (cm) by 1.0 cm and a 10 cm by 2 cm abrasion on the left lower extremity. Resident #11 sustained additional falls on 4/9/05 and 4/12/05 without injury. Interview with the APRN on 5/18/05 at 3:45 PM identified that the diagnosis of syringomyelia and the changes in the Elavil and Risperdal contributed to the falls. Clinical record review with the Minimum Data Set Coordinator on

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

5/18/05 at 3:45 PM, failed to provide evidence that care plan interventions and monitoring of potential side effects for psychoactive medications were implemented and/or conducted.

c. Resident #17's was admitted to the facility on 4/13/05 with diagnoses that included congestive heart failure and renal insufficiency. The Minimum Data Set (MDS) dated 4/13/05 identified short term memory deficit, some decision making difficulty in new situations, limited to extensive assistance for activities of daily living (ADL) and required partial physical support to stand. The care plan dated 4/13/05 identified a transfer and toileting deficit with interventions that included to provide extensive assistance of one staff for toileting and transfers. Facility documentation dated 4/16/04 identified Resident #17 was assisted to the bathroom and fell backwards sustaining a laceration on the left ear after Nurse Aide #3 left the resident unattended to dispose of soiled linen. Resident #17 was admitted to the hospital with a diagnosis of pneumonia and required sutures to approximate the wound. The Unit Manager on 5/23/05 at 9:00 AM in an interview stated Nurse Aide #3 was not aware Resident #11 could not be left unattended in the bathroom.

d. Resident # 21 diagnoses included dementia, osteoporosis and status post right hip fracture. An assessment dated 2/22/05 identified short-term memory loss, moderately impaired decision making abilities and limited assistance required for transfers and ambulation. A care plan dated 2/23/05 identified poor safety awareness with interventions that included to utilize a motion detector when in the bedroom and the use of a personal alarm at all times. A Fall Assessment dated 3/9/05 indicated that Resident #21 was able to remove and turn off the personal alarm and motion detector. Nurse ' s notes dated 3/9/05, 3/12/05 and 3/14/05 indicated Resident #21 made several attempts to stand independently activating the personal alarm. A nurse's note dated 3/20/05 at 11:30 AM identified that the resident was found on the floor in front of the wheelchair. Resident #21 had removed the personal alarm and attempted to ambulate without assistance. An assessment identified pain in the right hip, however an examination at the hospital indicated no injury. A nurse's note dated 3/22/05 at 5.00 AM identified Resident #11 was found lying on the floor complaining of severe right hip and back pain. The personal alarm had been removed and the motion detector did not sound. The physician was notified and directed to transfer to the emergency room for an evaluation. The hospital admission summary dated 3/22/05 indicated Resident #21 was admitted to the hospital with a diagnosis of left hip fracture. Although the facility was aware Resident #21 was able to remove and turn off the personal alarm and motion detector, a review of the clinical record with the Director of Nurses on

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

5/25/05 at 12:15 PM failed to identify that the care plan was reviewed or interventions implemented to prevent an accident.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3) and/or (j) Director of Nurses (2) and/or (m) Nursing Staff (2) and/or (o) Medical Records (2)(H).

19. Based on clinical record review and staff interviews for 2 of 17 sampled residents (Resident #s 7 and 22), the facility failed to maintain adequate hydration and/or monitor and assess for sufficient fluid intake, and/or develop and/or maintain policy and procedures for hydration to support and maintain health. The findings include:
    a. Resident #7's diagnoses included depression, renal insufficiency and osteoarthritis. The Minimum Data Set (MDS) dated 3/8/05 identified that the resident had no memory problems, was independent in eating, frequently incontinent of urine and experienced moderate pain on a daily basis. Resident Care Plans (RCP) dated 12/29/04 and 3/9/05 identified that the resident needed adequate hydration and is a "picky eater." Interventions included, in part, encouraging fluids with and between meals. Nurses notes from 3/4/05 through 3/11/05 identified that the resident was eating poorly and/or refusing meals, and/or complaining of no appetite and/or presenting with a deteriorating mood, and/or fatigued, and/or presenting with frequent complaints of pain. Further review of the nurse's notes identified that on 3/11/05 the resident was disimpacted of a large amount of hard stool had vomited on two occasions (30 cc and 50 cc) on 3/13/05, and infrequent documentation that fluids had been encouraged. A review of the meal consumption documentation from 3/5/05 through 3/17/05 indicated that the resident refused 14 of 38 meals ate less than 25% of 11 meals and 50% of 10 meals. The 3/17/05 Advanced Practice Nurse's (APRN) note indicated that the resident was unable to eat because of the pain that the mucous membranes were dry and the resident was unable to draw fluid up the straw to drink. The APRN ordered laboratory studies. The resident was transferred to the emergency room on 3/17/05. Review of hospital documentation identified that Resident #7 was admitted to the hospital with diagnoses, which included in part dehydration, acute renal failure, and hypercalcemia. A hospital physical examination revealed dry mucosa, laboratory results of the Blood Urea Nitrogen of 115 (normal range 8-20), creatinine of 3.2 (normal range 0.4-1.0) and a calcium of 14.4 (normal range 8.9-10.3). The resident was treated with a bolus of one liter of saline and then continued at 200 ml. per hour. The physician's assessment stated that the elevated calcium is likely

secondary to the patient's dehydration/volume depletion status. Review of the clinical record and interview with nursing staff on 5/18/05 at 11:40 AM indicated that the resident had not been on Intake and Output (I&O) monitoring from 3/4/05 through 3/16/05. In addition, record review identified that although the resident had been consistently consuming less than 50% of her meals with many meal refusals, Resident #7 had not been assessed for sufficient fluid intake prior to the hospitalization of 3/17/05 and/or that the physician had been notified of the decreased intake until 3/16/05.

i. Upon return from the hospital on 3/25/05; the resident was placed on I&O monitoring, which was discontinued on 5/2/05. Although the dietary note of 12/29/04 identified that the resident's fluid requirements were 1200 to 1500 cubic centimeters (ccs), the nutritional assessment dated 3/30/05 was lacking an assessment of fluid intake. A review of the I&O documentation from 3/25/05 through 5/2/05 indicated that the record was incomplete for 12 days and that the resident consumed less than 1000 ccs (range 590-990) on 13 of 34 days. Review of the clinical record and interview with nursing staff on 5/18/05 indicated that the resident's hydration status was not assessed during this time frame except on 4/23/05. The nurse's note dated 4/23/05 stated that the resident was resistant to accepting fluids and staff were questioning dehydration, however no further assessment was completed and/or documented. Although the resident's fluid consumption frequently does not meet the estimated fluid needs, interview with the Charge Nurse on 5/19/05 indicated that the I&O monitoring was discontinued because the resident improved and she is chronically below the fluid requirements. Although facility review identified other residents who were monitored for intake and output and consuming less than their estimated daily requirements, the facility was unable to provide any policy and procedures related to the provision of and/or monitoring for sufficient hydration. Interview with the Director of Nurses (DNS) on 5/19/05 at 9:30 AM identified that the facility did not have a procedure for hydration but rather relied on standards of practice. Upon request for an immediate plan, which included an assessment of all residents residing in the facility, fifteen additional residents were identified at risk for dehydration.

b. Resident#22 had diagnoses that included osteoporosis, fractured left hip and Paget's disease. An assessment dated 4/18/05 identified severe cognitive impairment and total dependence required for activities of daily living. A care plan dated 4/28/05 identified an unrepaired fractured left hip with interventions that included to obtain

intake and output every shift and to utilize a foley catheter. A Dietary progress note dated 4/27/05 identified an estimated daily fluid requirement of 1500 cubic centimeters (cc). The Intake and Output Record identified that from 4/14/05 through 4/30/05, Resident# 22 consumed the estimated requirement on 4/21/05. Additionally, the daily estimated fluid requirement was not consumed from 5/1/05 through 5/16/05, with an average intake that ranged from 1060 cc to 973 cc. A laboratory report dated 4/11/05 identified a Blood Urea Nitrogen (BUN) level of 11mg/dl (8-20 mg/dl normal range) on 4/11/05 and a BUN level of 17 mg/dl was recorded on 5/11/05. Review and interview of the clinical record with the Minimum Data Set Coordinator on 5/19/05 at 3:30 PM failed to identify that a hydration assessment and/or monitoring of fluid intake was completed. Interview with the Director of Nurses (DNS) on 5/19/05 at 9:30 AM identified that the facility did not have a procedure for hydration but rather relied on standards of practice.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (m) Nursing Staff (2)(A) and/or (o) Medical Records (2)(I).

20. Based on clinical record review, and interview for 2 of 14 sampled residents, (Resident #s 11 and 21) who received psychoactive medications, the facility failed to conduct behavior monitoring and/or obtain a diagnosis to indicate the use of the medication. The findings include:
    a. Resident #11 had diagnoses that included depression. A quarterly assessment dated 1/31/05 identified intact cognition, highly impaired vision, repetitive health complaints and tearfulness. A care plan dated 2/2/05 identified episodes of tearfulness, neediness and mood swings with interventions that included frequent one to one visits, reassurance and validation when anxious or emotional. A nurse's note dated 3/8/05 identified that Resident #11 verbalized emotional disturbance and exhibited paranoid behavior. An Advanced Practice Registered Nurse (APRN) progress note dated 3/9/05 identified the resident remained upset, felt useless and cried throughout the interview. Recommendations included to increase the dose of anti-depressant, re-evaluate in two weeks and weekly visits. An APRN progress note dated 3/10/05 identified irrational behavior, ruminating with paranoid ideations and Risperdal 0.25 milligrams twice a day was ordered. Clinical record review and interview with the Minimum Data Set Coordinator (MDS) on 5/24/05 at

11:00 AM identified that behavior monitoring was not done upon initiation of Risperdal.

b. Resident # 21 diagnoses included dementia, osteoporosis and compression fractures. An assessment dated 2/22/05 identified short-term memory loss and moderately impaired decision making abilities. A physicians order dated 3/18/05 directed to administer Paxil 10 milligrams (anti-depressant) at bedtime for fourteen days. Interview and review of the clinical record with the Director of Nurses at 5/25/05 at 12:15 PM failed to identify a diagnosis to substantiate the use of the antidepressant.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (m) Nursing Staff (2)(A).

21. Based on observation of the medication pass for 4 of 51 medications identified that medications were not administered in accordance with physician orders and/or standards of practice. The findings include:
    a. During the medication pass observation on 5/17/05 identified Resident # 10's diagnosis included vertigo. A physician order dated May 2005 directed to administer Antivert 12.5 milligrams (mg) twice a day at 8:00 AM and 8:00 PM. On 5/17/05 observation identified the 8:00 AM Antivert 12.5 milligrams (mg) was administered at 11:32 AM.
    b. Resident # 12's physician order dated 5/10/05 directed to administer Cephalexin 250 milligram (mg) (antibiotic) four times a day for ten days. On 5/17/05 observation identified the 8:00 AM dose was administered at 11:25 AM.
    c. Resident # 13's diagnoses included asthma and Parkinson's disease. A physician order dated 4/16/05 directed to administer Mirapex 1.0 milligram (mg) once a day at 8:00 AM and Mirapex 0.75 mg at 2:00 PM and 6:00 PM. Additionally, Atrovent 0.02 percent (%) solution via nebulizer at 6:00 AM, 10:00 AM, 2:00 PM and 6:00 PM. Observation on 5/17/05 identified the 8:00 AM dose of Mirapex was administered at 11:37 AM and the 10:00 AM dose of Atrovent was administered at 11:55 AM. Interview with the Licensed Practical Nurse #2 on 5/17/05 at 12:10 PM indicated she was called into work and when she arrived until 10:45 AM, she was assigned to complete the medication pass. The medication nurse indicated that the time for subsequent doses of medications that were administered late would be adjusted.

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The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (q) Dietary Services (2)(D).

22. Based on observations, staff interview and review of facility policy, the facility failed to store, prepare and distribute food under sanitary conditions. The findings include:
    a. On 5/17/05 at 9:30 AM during a tour of the dietary department, it was observed that debris had collected in the grooves of the metal floor divider near the tray line and into the dishwashing room. Interview with the Dietary Supervisor on 5/18/05 at 10:00 AM indicated that although the floor is cleaned daily, staff do not clean the grooves in the floor. Further interview with the Dietary Services Coordinator on 5/18/05 at 10:25 AM indicated that the grooves were last cleaned on 4/13/05.
    b. On 5/17/05 observation identified that the floor edges were soiled in front of the refrigerator, beneath the knife shelf and in front of the lower level refrigerator. Ceramic tiles in the lower level walk in freezer were noted to be broken at the edges with debris collected in the broken areas. The freezer handles were noted to be soiled with dust.
    c. Interview with the Executive Chef on 5/17/05 at 12:15 PM indicated that the facility occasionally tested the concentration of the sanitizer used in the three compartment sink, however documentation of the testing was not maintained. Interview with the Dietary Services Coordinator on 5/18/05 at 10:00 AM indicated that the facility did not have a policy and procedure for monitoring the concentration of sanitizer in the three compartment sink, nor was information available to indicate the acceptable concentration of sanitizer required. On 5/18/05 at 10:15 AM a sanitizer concentration test indicated 100 parts per million concentration. After surveyor inquiry, on 5/19/05, the facility contacted the vendor and the acceptable concentration of the sanitizer was between 200 and 300 parts per million.
    d. A review of the Three Day Emergency Food supply on 5/17/05 at 9:30 AM indicated that nine (9) cans of tomato soup had an expiration date of August 2004. Interview with the Dietary Staff responsible for rotating the emergency food supply indicated that the stock is rotated every two years. Interview with the Dietary Services Coordinator on 5/18/05 at 9:10 AM confirmed that the soup had an expired date.
    e. Observation on 5/17/05 at 9:10 AM of the dishwasher rinse cycle indicated that the water temperature was 174 degrees. Interview with the Dietary Supervisor on 5/18/05 at 9:10 AM identified that the rinse water temperature needs to register 180 degrees to sanitize the dishes. After surveyor inquiry, dietary staff turned on the

water temperature booster to raise the temperature. All dishes previously washed were re-washed and rinsed at the correct temperatures. The facility procedure for the dishwashing machine directs staff to check the temperature dials during the dishwashing process to determine if wash and rinse temperatures are being maintained. Interview with the Dietary Services Coordinator on 5/18/05 at 9:10 AM indicated that staff does not document dishwasher water temperature monitoring.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3) and/or (n) Medical and Professional Services (6).

23. Based on clinical record review, facility documentation review and staff interviews for 1 of 9 sampled residents (Resident #11), with mood and behavior indicators, the facility failed to implement physician delegation of tasks in an appropriate manner. The findings include:
    a. Facility documentation review identified that the Advanced Practice Registered Nurse (APRN) with a specialty in psychology and mental health, was an employee of the facility's management team. The APRN had collaborative agreements with the Medical Director and the consultant Psychiatrist. Review of Resident #11's clinical record on 5/18/05 at 3:45 PM, identified that the APRN evaluated the plan of care and prescribed medications on 3/9/05 and 3/10/05. Clinical record review and interview with the APRN on 5/23/05 at 10:00 AM identified that although she ordered medication for Resident #11, she did not have a collaborative agreement with Resident#11's Attending Physician. The APRN reported that she evaluates any resident in the facility, as need arises and was not aware that a collaborative agreement was necessary with each physician for her to participate in the residents' medical management. The APRN indicated she thought the collaborative agreement with the Medical Director was sufficient.
    b. Resident #11's diagnoses included depression. A review of the clinical record from 3/19/04 to 5/19/05 identified that although treatment and medications were routinely prescribed by the Advanced Practice Registered Nurse (APRN), the consulting Psychiatrist did not evaluate the resident prior to or after changes to the treatment plan. Interview with the APRN on 5/23/05 at 10:00 AM identified she had a collaborative agreement with the consultant Psychiatrist and she was not aware the Psychiatrist needed to physically evaluate the resident. The APRN stated she had telephone communication with the Psychiatrist regarding the residents' treatment plan. Interview with the Director of Nurses on 5/24/05 at 11:00 AM

indicated that the consultant Psychiatrist visited occasionally however did not periodically review and provide supervision to the APRN.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (t) Infection Control (2)(A).

24. Based on facility documentation review and staff interview, the facility failed to maintain a record related to infections. The findings include:
    a. Facility documentation review and interview with the Infection Control Nurse (ICN) on 5/19/05 at 10:00 AM identified that the facility failed to maintain a system to identify residents with a history of previous communicable diseases that included methicillin resistant staphylococcus aureus (MRSA). The ICN indicated that active infections are tracked; however once colonized, the residents were removed from the list.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (m) Nursing Staff (2)(C).

25. Based on observation, clinical record review and staff interview for 1 of 4 sampled residents (Resident # 6), with a history of pressure ulcer, the facility failed to ensure that treatments were provided in a manner to prevent infection. The findings include:
    a. Resident#6's diagnoses included chronic pressure ulcer and atrial fibrillation. The Minimum Data Set (MDS) dated 4/20/05 identified the resident with memory deficits and independent in most activities of daily living. Observation of a dressing change on 5/19/05 at 2:15 PM identified Licensed Practical Nurse (LPN) #4 opened the tube of medication and without the benefit of lipping the tube, squeezed the medication directly onto the clean gauze. After completion of the dressing change, LPN #4 carried the soiled dressings from the room down the hall to the nurses' station without the benefit of enclosing the soiled items in a sealed bag. In an interview at that time, LPN #4 stated that she did not lip the medication prior to use because she always provided the daily dressing change. Furthermore, LPN #4 stated that facility policy directs to enclose soiled dressings in a plastic bag prior to disposal.

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The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (m) Nursing Staff (2)(C) and/or (t) Infection Control (2)(A).

26. Based on observation, clinical record review, and staff interviews for 1 of 4 sampled residents (Resident #1), with a history of pressure ulcer, the facility failed to conduct handwashing during a wound treatment to prevent infection. The findings include:
    a. Resident#1 had diagnoses that included paraplegia, anemia, renal insufficiency. A quarterly assessment dated 4/7/05 identified intact cognition, incontinence of bowel and bladder and a Stage II pressure ulcer. Observation on 5/19/05 at 2:15 PM of a wound treatment identified a 1.2 centimeter (cm) x 1.0 cm open area on the coccyx. The Licensed Practical Nurse (LPN) #3 washed her hands, donned gloves and removed the soiled dressing. The wound bed was sprayed with Constant Clens and then patted dry with gauze. Utilizing the same gloves, LPN #3 retrieved a jar of Silvadene cream and placed it onto the bed, opened a pack of Q-Tips and the protective dressing. LPN #3 applied the Silvadene cream to the wound area and covered it with a dressing. She discarded the dressing wrappings, used materials and removed her gloves. LPN #3 in an interview on 5/19/05 at 2:15 PM stated she did not wash/sanitize or change the gloves after removing the soiled dressing because she had a small laceration on her finger.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3).

27. Based on observation and staff interviews for 2 of 3 clothes dryers, the facility failed to maintain the equipment in safe operating condition. The findings include:
    a. Observation of the laundry on 5/19/05 at 10:30 AM with the Assistant Director of Housekeeping and Maintenance (ADHM) identified that two of three clothes dryers had excessive lint build-up in the vent system. The ADHM stated the facility did not have a policy directing when to clean the vent systems attached to the dryers.

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THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3).

28. Based on observation and staff interviews the facility failed to ensure that electric wheelchair and/or scooter batteries were recharged in a safe manner. The findings include:
    a. Observation and on 5/18/05 at 9:45 AM identified battery recharging was being conducted on a motorized custom wheelchair in the Whitridge hallway. The Unit Manager in an interview on 5/18/05 at 10:00 AM indicated that the motorized wheelchair was routinely recharged in the hallway and she was unaware the practice was not safe. Interview with the Maintenance Director on 5/23/05 at 1:45 PM identified that motorized scooters and wheelchairs were charged in the hallway on the respective units during the 11:00 PM - 7:00 AM shift. Subsequent to surveyor inquiry motorized wheelchairs and scooters were designated to be recharged in a non-resident room that provided ventilation and a closed door.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3) and/or (h) Medical Director (2)(B).

29. Based on clinical record review and review of facility documentation and Policy and Procedures, the facility failed to administer in a manner to ensure care and services were provided effectively. The findings include:
    a. Review of Resident #s 10, 12, 28, 29 and 33's clinical record indicated the residents were receiving palliative care from a range of fifteen (15) to thirty-four (34) months. The facility's Palliative Care Policy indicated that in order to activate palliative care, death is anticipated within six months. Interview with the Director of Nurses on 5/24/05 at 9:00 AM identified that palliative care was reviewed and updated by the Attending Physician during scheduled visits. However, a review of the physician progress notes failed to indicate why the residents' were receiving palliative care beyond six months.
    b. Review of the facility's Quality Assurance (QA) Policy identified that the Administrator is responsible for the overall continuous quality improvement (CQI) program within the facility. Further review identified that the Administrator is a member of the CQI Steering Council that meets quarterly in conjunction with the Medical Staff meeting. The Administrator will review and act upon the reports of the individual committees (Infection Control, Pharmacy and Safety). Review of

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

the Medical Staff meeting minutes from 2/18/04 through 2/16/05 failed to identify that consistent QA committee reports were reviewed. Additionally, the report lacked documentation from the Infection Control and Safety committees. Although weight loss was as a problem on 2/18/04, the QA meeting minutes failed to identify what measures to address weight loss were implemented.

c. Review of facility Policy and Procedures identified the facility lacked procedures how to identify residents at risk for dehydration, hydration assessments and intake and output. Interview with the Director of Nurses on 5/19/05 at 9:30 AM reported that the facility failed to develop a system for monitoring residents at risk for dehydration and/or hydration assessments.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3) and/or (h) Medical Director (2)(B).

30. Based on clinical record reviews, facility documentation review and staff interviews the facility failed to ensure that a system for revision and review of policies and procedures and/or supervision of the Advanced Practice Registered Nurse (APRN) was conducted by the Medical Director. The findings include:
    a. Interview with the Director of Nurses on 5/23/05 at 10:00 AM identified that the APRN prescribed medication and treatment to residents in the facility who exhibited mood and behavior symptoms. Facility documentation review identified that the APRN's clinical specialty was psychology and mental health. The APRN had a collaborative agreement with the Medical Director and the consultant Psychiatrist. Interview with the Medical Director on 5/24/05 at 11:00 AM identified the facility lacked a system to provide a review and clinical oversite of the care and treatment provided to residents by the APRN. Although the Psychiatrist visited the facility occasionally, periodic supervision and review of the APRN's scope of practice was not conducted.
    b. Review of the facility's Policy and Procedure Manual failed to identify that policies and procedures were developed for dehydration risk and/or intake and output and/or hydration/dehydration assessments. Further review identified that although the facility developed a Bowel Policy, residents' who were ambulatory were not assessed and/or monitored. Additionally, the policy for monitoring residents' who received Digoxin was not based on current professional standards. Interview with the Medical Director on 5/24/05 at 11:00 AM identified that the facility lacked a system to review nursing policies and procedures and a review was conducted if a problem was identified.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3).

31. Based on facility documentation review and staff interviews, the facility failed to address identified quality assurance issues and/or implement corrective actions. The findings include:
    a. The facility Continuous Quality Improvement (CQI) Policy identified the responsibility of the CQI Steering Council is to meet quarterly during the medical staff meeting to review reports and/or to act on reports submitted by the CQI committees. CQI committees that include Infection Control, Pharmacy and Safety are directed to submit reports every quarter. Additional areas of review include clinical, financial, environmental and regulatory compliance services. The Medical Staff meeting minutes from 2/18/04 through 2/16/05 failed to identify that reports were submitted from the Infection Control and Safety committee. Furthermore, Pharmacy committee reports were submitted on only two of four quarters. Interview with the Staff Development Nurse (SDN) who is responsible for the CQI program, on 5/19/05 at 10:00 AM stated that quality assurance issues and/or topics are only derived through the care plan process and other indicators are not utilized.

FLIS Independent Nurse Consultant Guidelines

Relationship between Independent Nurse Consultant (INC) and DPH includes:

- An INC is utilized as a component of DPH's regulatory remedy process. An INC may be agreed upon as a part of a Consent Order between the institution and the Department when significant care and service issues are identified.
- The INC has a fiduciary or special relationship of trust, confidence and responsibility with the Department.
- The INC's responsibilities include:
  - Reporting to the Department issues and concerns regarding quality of care and services being provided by the institution.
  - Monitoring the institution's plan of correction to rectify deficiencies and violations of federal/state laws and regulations. Reports to Department positive and negative issues related to said oversight.
  - Assessing administration's ability to manage and the care/services being provided by staff.
  - Weekly reporting to the Department of issues identified, plans to address noncompliance and remediation efforts of the institution.

Relationship between INC and the Institution:

- The INC maintains a professional and objective relationship with the institutional staff. The INC is a consultant, not an employee of the institution. The INC exercises independent judgment and initiative to determine how to fully address and complete her/his responsibilities. The institution does not direct or supervise the INC but must cooperate with and respond to requests of the INC related to her fulfilling her/his duties.
- The INC's responsibilities include:
  - Assessment of staff in carrying out their roles of administration, supervision and education.
  - Assessment of institution's compliance with federal/state laws and regulations.
  - Recommendations to institutional administration regarding staff performance.
  - Monitoring of care/services being provided.
  - Assists staff with plans of action to enhance care and services within the institution.
  - Recommendation of staff changes based on observations and regulatory issues.
  - Weekly reports to the institution re: assessments, issues identified, and monitoring of plans of correction.
  - Promotes staff growth and accountability.
  - May present some inservices but primary function is to develop facility resources to function independently.
  - Educates staff regarding federal/state laws and regulations.